

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH mailed to 63-017109

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 228 Primary Registration District No. 3054 Registrar's No. 62

STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		c. CITY OR TOWN <u>FRANKFORD</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u></u>	
3. NAME OF DECEASED (Type or print) <u>DE ANNA MARIE JENNINGS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (City and state or country) <u>LOUISIANA Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM H. JENNINGS</u>		13b. MOTHER'S MAIDEN NAME <u>CAROL SUE JOLLY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>WILLIAM H. JENNINGS</u>		Address <u>FRANKFORD Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> DUE TO (b) <u>Acute Bacteremia</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u></u>	
20g. COUNTY <u></u>		20h. STATE <u></u>	
21. I attended the deceased from <u>4-18-63</u> to <u>4-18-63</u> and last saw her <u>alive</u> on <u>10:26 PM 4-18-63</u> Death occurred at <u>10:26 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Joe Martin, M.D.</u>		22b. ADDRESS <u>Louisiana, Mo.</u>	
22c. DATE SIGNED <u>4-22-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>APR. 21-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY - FRANKFORD Mo.</u>	
23d. LOCATION (City, town, or county) <u></u>		(State) <u></u>	
24. FUNERAL DIRECTOR <u>MEGOWN FUNERAL HOME FRANKFORD Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-20-63</u>	
26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>			

(Licensed Embelmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Don Fields Maynor

Licensed Embalmer No. 4092

P. O. Address Frankford Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.